OSF

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From: Monica Deignan, Family Care Program Manager
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Subject: Maximizing Medicare and Choice of Providers

Note: This memo updates and replaces the May 7, 2002 memo on the same subject.

As with Medicaid, the Family Care CMO is the payer of last resort, and the CMO works to assure Medicare is paying for covered services before the CMO pays. In some instances, however, maximizing Medicare may limit a member's choice of providers. For example, in a recent situation a dually-eligible CMO member declined Medicare home health aide services for which he was eligible, because he wanted to continue receiving services from his current personal care worker. Because the member signed off on his Medicare benefits, Medicare did not pay for home health services and that cost was shifted to the CMO.

CMOs may place an expectation on members that they use Medicare benefits for which they are eligible. In order to place this expectation on members, CMOs must include the following information in the member handbook:

- It is the expectation that Medicare benefits will be elected by members who are currently enrolled in Medicare Parts A and/or B and that the Medicare benefit is maximized; and
- That if the member is currently enrolled in Medicare Parts A and/or B and chooses not to elect to use his or her Medicare benefits, the CMO may refuse to pay for costs that Medicare would otherwise cover. (This is consistent with Federal Managed Care Regulations at 42 CFR 438.210 identifying covered services and "medically necessary services." And is the expectation in other Medicaid programs as well.)

Members cannot be required to participate in the Medicare hospital (Part A) or Medicare Supplementary Medical Insurance (Part B) even if they are otherwise entitled or eligible to enroll in the program. (Medicare entitlement and enrollment criteria can be found in 42 CFR 406.5 and 42 CFR 407.10). If financial considerations have impacted a member's decision not to participate in the Medicare health insurance program, those members should be referred for counseling regarding eligibility for the Medicare Premium Assistance or Medicare Buy-In under the Medicaid program. This counseling can be provided by the elderly or disability benefits specialists or by the Economic Support unit.

This approach balances the goal of maximizing Medicare with member choice of provider. CMO members need to be provided adequate information about their choices in order to make an informed choice. After reviewing the handbook and considering the financial impact, in most instances members will probably choose to use their Medicare benefits. Any negative effects this policy may have on member choice would be minimized if the CMO is willing to make exceptions and allow use of non-Medicare providers if that would prevent undue hardship for the member, or be found necessary to achieve members' outcomes.

In order to implement this policy, CMOs will need to write language for their member handbooks that explains the bulleted points above, and have that language approved by DHFS (as all member handbook language must be approved by the state). Since CMOs may not be printing new handbooks for several months, the CMO could print inserts to the current handbooks and send to all current enrollees. In addition, the CMO will need to provide this updated language to the local resource center and enrollment consultants so it can be reviewed with potential enrollees.

The CMO may want to develop guidelines for interdisciplinary teams to use in making decisions about Medicare services, and CDSD staff would be happy to collaborate in the development of such guidelines.

If the CMO encounters a situation in which a member wants to use a non-Medicare caregiver for services that Medicare would otherwise cover, the CMO may want to negotiate with the Medicare provider to hire and train that caregiver so that the Medicare benefit could be maximized.

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